Date of Hearing: May 25, 1999

ASSEMBLY COMMITTEE ON JUDICIARY
Sheila James Kuehl, Chair
AB 1380 (Villaraigosa) – As Amended: May 24, 1999

SUBJECT: MEDICAL INJURY COMPENSATION REFORM ACT OF 1975 (MICRA)

KEY ISSUES:

1) HAS MICRA MET ITS INTENDED OBJECTIVES OF STABILIZING MALPRACTICE INSURANCE PREMIUMS AND MAINTAINING ACCESS TO QUALITY HEALTH CARE, WHILE ENSURING APPROPRIATE COMPENSATION FOR VICTIMS OF MEDICAL MALPRACTICE?

2) SHOULD MICRA'S CAP ON "PAIN AND SUFFERING" DAMAGES BE ADJUSTED ANNUALLY, CONSISTENT WITH THE APPROACH OF SEVERAL OTHER STATES, TO REFLECT INCREASES IN THE COST OF LIVING?

SUMMARY: Adjusts the cap on non-economic damages contained in the Medical Injury Compensation Reform Act of 1975 (MICRA) annually to reflect changes in the cost of living, and sets forth various legislative findings about the need to reform MICRA. Specifically, this bill:

1) Sets forth various legislative findings, including that: a) "Since the law was enacted 24 years ago, the cost of living has increased so that the two hundred fifty thousand dollar ($250,000) cap on damages is estimated to be worth eighty-four thousand dollars ($84,000) today;" and b) "MICRA disproportionately affects women, children, the elderly, and lower income Californians because they are less likely than other citizens to have incurred substantial economic loss and must rely on non-economic damages as the main source of compensation for the injuries suffered because of medical negligence."

2) Adjusts the MICRA cap annually to reflect changes in the cost of living, keyed to the Consumer Price Index.

EXISTING LAW:

1) Provides generally that personal injury victims are entitled to actual (otherwise known as compensatory) damages, as well as punitive (otherwise known as exemplary) damages when appropriate. (Civil Code sections 3333 and 3294.)

2) Includes in the damages available for personal injuries full compensation for "all the detriment proximately caused" by the injuries, including: impairment of earning capacity (Rodriguez v. McDonnell Douglas Corp. (1979) 87 Cal.App.3d 626); medical care and other expenses (Gastine v. Ewing (1944) 65 Cal.App.2d 131); aggravation of a prior condition (Smith v. Schumacker (1938) 30 Cal.App.2d 251); susceptibility to subsequent injury (Ensign v. Southern Pac. Co. (1924) 193 Cal.

311); loss of consortium (Rodriguez v. Bethlehem Steel Corp. (1974) 12 Cal.3d 382); and damages for pain and suffering (Merrill v. Los Angeles Gas & Elec. Co. (1910) 158 Cal. 499).

3) Defines economic damages as damages which compensate a victim for quantifiable out-of-pocket costs, such as medical expenses, lost earning capacity, and lost time at work. (See, e.g., J'Aire Corp. v. Gregory (1977) 24 Cal.3d 799.)

4) Defines non-economic damages as non-quantifiable damages, including compensation for pain and suffering. (Civil Code section 1431.2.)

5) Caps at $250,000 (without any adjustment for changes in the annual cost of living) the non-economic damages available to victims in personal injury actions against health care providers based on professional negligence. (Civil Code section 3333.2(b), "MICRA".) However, a mother and child may each be entitled to non-economic damages of up to $250,000 in certain obstetrical negligence cases. (Burgess v. Superior Court (1992) 2 Cal.4th 1064, 1083.)

6) Defines "health care provider" to include any person licensed or certified pursuant to: (a) Business and Professions Code section 500 (which includes all healing arts professionals); (b) the Osteopathic Initiative Act; (c) the Chiropractic Initiative Act; and (d) Health and Safety Code section 1400 (county medical facilities). The term health care provider also includes any clinic, health dispensary or health facility licensed pursuant to Health and Safety Code section 1200, and any legal representative of a health care provider. (Civil Code section 3333.2 (b)(1).)

7) Defines "professional negligence" as a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. (Civil Code section 3333.2(b)(2).)

8) Provides a three-year statute of limitations in professional negligence actions against a health care provider. (Code of Civil Procedure section 340.5.)

9) Requires the court, on request of either party, to order periodic payments for future damages in professional negligence actions against a health care provider when such damages equal or exceed $50,000. (Code of Civil Procedure section 667.7.)

10) Authorizes mandatory arbitration agreements in medical services contracts. (Code of Civil Procedure section 1295.)

11) Provides, under the so-called "collateral source" rule, that evidence of certain benefits payable to the plaintiff, such as social security payments and benefits received under group health plans, may be introduced by the defendant at trial. If such evidence is introduced, however, the plaintiff may prove the cost of such benefits. (Civil Code section 3333.1(a).)

12) Requires that 90 days' notice of an intention to file suit be given to all named defendants. Failure to comply with this notice requirement does not invalidate the proceedings but is grounds for professional discipline of the plaintiff's attorney. (Code of Civil Procedure sections 364 and 365.)

13) Limits the contingency fee that may be charged by counsel in medical malpractice actions. (Business and Professions Code section 6146 and Code of Civil Procedure section 1049.)

14) Limits rate increases for medical malpractice insurance pursuant to the terms of Proposition 103 of 1988. (Insurance Code section 1861.13.)

FISCAL EFFECT: Unknown

COMMENTS: This bill touches upon one of the most hotly debated and challenging public policy issues confronting state policy-makers in recent years, namely, whether the state's Medical Injury Compensation Reform Act , otherwise known as MICRA, is in need of some reform, or whether any changes to this statutory scheme will adversely affect access to quality health care and will unfairly burden the state's health care providers. The bill initially was heard by the Committee on May 11, 1999, at which time the author informed the Committee he would return the legislation for a subsequent policy hearing after the bill was amended. The bill now before the Committee limits its reform of MICRA to adding a mechanism into the $250,000 MICRA cap to reflect annual changes in the cost-of-living.

In support of this legislation, the author provided the following comments to the Committee:

> I introduced AB 1380 to take a serious look at the Medical Injury Compensation Reform Act (MICRA) of 1975. I believe revision to MICRA is necessary to balance the interests of health care professionals with the crucial need to ensure an adequate remedy for medical malpractice victims and guarantee consumer protection. Victims do not have an adequate remedy, and the bad physicians are under no pressure to improve as the Medical Board has insufficient funding to discipline the bad doctors….Furthermore, because children, seniors, women, and low-income individuals have low quantifiable economic damages, the MICRA cap has had an adverse affect on the ability of these individuals to obtain representation and full compensation…
>
> In addition, medical malpractice victims have had a difficult time obtaining representation due to the costs of litigating these types of cases and the low probability of a favorable outcome. Oftentimes, neither the attorney nor the victim have the necessary finances to pay for the costs associated with preparing the case for trial…
>
> Under MICRA, medical malpractice insurance rates have not gone down. Doctors never saw any reduction in premiums … they simply stabilized….According to a study conducted by the Consumer Federation of America, medical malpractice insurance represents less than 0.6% of health care costs. California's aging population, staffing expenses, prescription drugs, and medical equipment are the real factors increasing health care costs….

> I realize we must work on several fronts to address the access problem. However, I do not believe that Californians should be required to sacrifice access to justice in exchange for access to healthcare. There is room for both.

In further support of the need to reform MICRA, the Speaker points to a 1997 California opinion poll conducted by the firm of Fairbank, Maslin, Mauslin & Associates (on file with the Committee), which found strong public support for reforming MICRA, including 74% statewide approval for removing MICRA's cap on non-economic damages.

Background: Given the focus on MICRA's cap on non-economic damages, many people understandably assume that MICRA is solely a limit on the amount of "pain and suffering" damages available to victims of medical malpractice. This is not the case. MICRA is not one statute, but a complex series of laws that took effect in 1975 to limit the legal liability of health care providers and fashion a litany of special rules for medical malpractice cases. MICRA actually encompasses all of the following:

1. Limits the contingency fee counsel may receive in medical malpractice cases.
2. Vests the Medical Board with the responsibility to protect the public from incompetent physicians.
3. Permits a health care provider charged with medical malpractice to introduce evidence of a patient's receipt of compensation from "collateral sources," such as insurance policies.
4. Limits the time in which a medical malpractice action can be commenced.
5. Requires a patient to provide 90 days' notice of his or her intent to sue so as to encourage settlement.
6. Permits a contract for medical services to include a binding arbitration requirement.
7. Permits periodic payment awards, rather than a lump sum award, for future damages.
8. Imposes a strict limit of $250,000 on non-economic damages.

Legislative Backdrop: MICRA was one of the first and most well-known "tort reforms" adopted by any jurisdiction in the United States. According to legislative analyses when MICRA was adopted, the primary purpose of the measure was to reduce the cost of medical malpractice litigation and restrain a perceived explosion in the cost of medical malpractice insurance while preserving the rights of medical malpractice victims to receive sufficient compensation for their injuries. As noted in a recent article about MICRA's passage and the subsequent enactment of Proposition 103, "Rebellion spread among California's physicians in 1975, as malpractice insurance rates jetted into the rarefied air of triple-digit inflation. The state's major group carriers announced massive hikes: Travelers, 486 percent in Southern California and 341 percent in Northern California; Argonaut, 320 percent; and CNA, 190 percent. But doctors didn't get mad at their insurers. They got mad at the lawyers who brought malpractice cases." (Tom Dresslar, "Prop. 103 Could Be Factor In Fight Over MICRA Cap," *San Francisco Daily Journal*, May 10, 1999, p. 1. Hereafter "Dresslar".)

The perception of crisis in this arena peaked in 1975, when Travelers Indemnity Company stunned Los Angeles area doctors by warning them that their malpractice insurance rates would increase five-fold. Governor Jerry Brown called a special session to try to reduce the cost of medical malpractice insurance in California, and in the face of extensive calls for legislative action, the Legislature enacted the wide ranging laws noted above.

Approximate Status of Damage Caps, and COLA Indexes, Among the States: After the passage of MICRA, many states enacted limits on damages in so-called "med-mal" cases. However, a 1998 survey of the approximate status of damage caps in the nation by the law firm of McCullough, Campbell & Lane of Chicago suggests that California is in the minority of states with such caps, it has one of the nation's lower caps on non-economic damages, and it does not contain a cost-of-living adjustment built into the law, an approach adopted by several other states. (Survey on file in the Committee. The source of this information is also available at the law firm's web site at "www. mcandl.com ".) Though some state data now may be outdated, the pattern provided by the survey may be informative for the Committee.

The following 30 jurisdictions currently appear to have no damage caps at all, either because they have never enacted them or because their courts have found them to be unconstitutional: Alabama; Arizona; Arkansas; Connecticut; Delaware; District of Columbia; Florida; Georgia; Illinois; Iowa; Kansas; Kentucky; Louisiana; Maine; Minnesota; Mississippi; Nebraska; Nevada; New Hampshire; New Jersey; New York; North Carolina Oklahoma; Pennsylvania; Rhode Island; South Carolina; Te nnessee; Vermont; Washington; and Wyoming.

The following 20 states appear to have caps on non-economic damages as noted, several of which also have some form of a cost-of-living index like that contained in this bill: Alaska ($500,000), Colorado ($250,000), Hawaii ($375,000), Idaho ($468,000 adjusted for inflation), Indiana ($750,000 total damages), Maryland ($545,000 adjusted for inflation), Massachusetts ($500,000), Michigan ($500,000), Missouri ($516,000), Montana ($250,000), New Mexico ($600,000 total damages), North Dakota ($500,000), Ohio ($500,000 total damages), Oregon ($500,000), South Dakota ($500,000), Texas ($1.321 million adjusted for inflation), Utah ($250,000), Virginia ($1,000,000), West Virginia ($1,000,000),and Wisconsin ($383,000 adjusted for inflation). Thus, of the minority of states which have some form of cap on non-economic damages, the average cap in the United States appears to be in the range of $500,000.

Judicial Backdrop: The California Supreme Court has reviewed the provisions of MICRA on several occasions. The constitutionality of MICRA was settled in 1985, when the Court upheld the Act's constitutionality against Due Process and Equal Protection challenges in Fein v. Permanente Medical Group (1985) 38 Cal.3d 137, app. dism., 474 U.S. 892, 88 L.Ed.2d 215. Most recently, the Court considered MICRA in the case of Dawnelle Barris v. County of Los Angeles (1999) 20 Cal.4th 101. In that case, the Court held that damages awarded under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. section 1395dd, otherwise known as the nation's "patient dumping" law) are subject to the $250,000 MICRA limit on non-economic damages. (The facts of that tragic case are discussed below.)

How the MICRA Cap Works in Practice: Prior to summarizing how the MICRA cap works in "real life" cases, it is important to recall that in such cases, a jury has already determined what it believes are the appropriate damages that should be awarded the victim of medical malpractice. (Indeed, as noted above, many other state courts have invalidated such damages caps on the grounds these statutory limitations improperly invade the jury's right to determine a victim's damages.) Under the cap procedure, once a jury comes back with an award of non-economic damages in excess of the current $250,000 cap, the award must be reduced by the court. (Of course, many times juries award non-economic damages less than the cap amount, so the MICRA cap is never triggered.) The reduction in the damages awarded

by the jury typically occurs after the jury is excused, so jurors often do not know that the malpractice victim in their case will not receive the full amount of damages they determined to be appropriate.

The Personal Side of MICRA -- Some Recent Cases Where the Cap Was Applied: Following are three cases where the MICRA cap substantially reduced the amount of "pain and suffering" damages found by the jury to be appropriate for the victim of medical malpractice:

Mychelle Williams: In this case, a Southern California jury found that Mychelle, an eighteen-month-old infant, died because defendant health care providers negligently left Mychelle untreated for 3 ½ hours with a life-threatening condition, due to the fact that she was a Kaiser member and thus her insurance would not cover her treatment at that hospital. Because Mychelle was a child without lost wages, the only economic damages were $3,000 in expenses to bury Mychelle. The jury also awarded $1,350,000 in non-economic damages: That amount was reduced to $250,000 because of the MICRA cap. (Dawnelle Barris v. County of Los Angeles, supra, 20 Cal.4th at 107.)

Frank Quintana, Sr.: In this case, Mr. Quintana underwent anticipated out-patient hernia repair surgery at Cecil & Ida Green Hospital of Scripps Clinic in La Jolla. The hernia repair was uneventful; however, Mr. Quintana subsequently suffered oxygen starvation because his physician negligently removed the endotracheal tube too soon. The oxygen deprivation resulted in cardiac arrest and Mr. Quintana died two weeks later. The jury found negligence and also determined (by a vote of 10-2) that Scripps negligently destroyed evidence. Because Mr. Quintana was retired, he had no economic loss other than the $7,831.00 the jury awarded in funeral expenses. In addition to these relatively minor economic losses, the jury awarded the plaintiff $373,000 in non-economic damages. However, the court subsequently reduced the "pain and suffering" damages to $250,000 because of the MICRA cap. (Quintana v. Gagnon et. al., Case # 70627, County of San Diego Superior Court, Date of Verdict December 4, 1997.)

Kim Martin: In this case, Kim Martin, a 40-year-old woman from San Diego, died when her dentist negligently ignored instructions in her written chart, as well as oral conversations detailing her allergies and anaphylactic reactions, and gave her medicine that killed her. The dentist also failed to intubate her when she stopped breathing after the severe reaction. A San Diego jury found the dentist negligent and made the following damages determinations: $50,068 for past medical expenses; $1,539.97 for funeral expenses; and $400,000 for non-economic damages. However, the court subsequently reduced the "pain and suffering" damages to $250,000 because of the MICRA cap. Although Miss Martin had a small business, her parents (the plaintiffs) could not claim lost wages since she did not support them. (Martin v. Smith, Case # 717299, County of San Diego Superior Court, Date of Filing January 14, 1998.)

Key Areas of Debate: This legislation strictly limits its reform of MICRA to the issue of whether a cost-of-living adjustment ought to be added to the current cap on non-economic damages, not whether there should be any cap at all. This analysis therefore shall focus solely on the dozen or so key "flash-points" that invariably arise in the debate over the merits of the MICRA damages cap.

Issue #1: What Is the Current Value of the MICRA Cap? According to the Consumer Attorneys of California, U.S. Department of Labor statistics indicate that inflation makes the current $250,000 MICRA cap worth only about $83,000 in year 2000 dollars. They also assert that these government statistics

indicate the cap would need to be increased to $753,000 by the year 2000 just to maintain the current cap in 1976 dollars. Opponents contend, however, that while the non-economic damages cap may have lost value over the years, it has more than been made up for with the increase in economic damage awards during the same period.

Issue #2: Do Malpractice Victims Typically Receive Punitive Damages? Some critics of this bill argue that the fact that plaintiffs are not limited under MICRA from receiving unlimited punitive damages strongly mitigates against the need to raise the cap on "pain and suffering" damages. They assert that the availability of unlimited punitive damages in egregious cases obviates the need for higher available non-economic damages.

Consumers for Quality Care states, however, that this argument conveniently ignores the difficult proof hurdles facing plaintiffs attempting to convince a jury they are entitled to receive punitive damages. They note that punitive damages may be awarded in med-mal cases only when a victim can prove by clear and convincing evidence that the health care provider was guilty of "oppression, fraud, or malice."

In addition, Consumer Attorneys of California notes that recent studies show that punitive damages are rarely awarded by juries. For example, a recent *Wall Street Journal* article on a punitive damages study that was conducted by the National Center for State Courts reported the following:

> Punitive damages are generally modest, and meted out in only the most extreme circumstances….According to the study, most punitive damage awards aren't random, as critics have argued, but instead are closely tailored to the amount of compensatory damages, such as medical expenses and lost wages….
>
> Plaintiffs were awarded punitive damages in just 6% of the jury verdicts in which the plaintiffs prevailed. Because plaintiffs succeeded about half the time, punitive damages were awarded in just 3% of all jury trials. (July 16, 1996.)

Issue #3: Is Medical Malpractice Litigation to Blame for Rising Health Care Costs? Professional Liability Insurers assert that MICRA's current "un-indexed" cap has helped keep California health care costs down, and, conversely, that increasing the MICRA cap now or in the future will increase the cost of medical malpractice insurance for physicians and other health care providers. They state that a recent survey comparing premium costs by specialty in Florida, Michigan, New York, and California, showed that annual savings in insurance premiums to California physicians due to the current cap in California range from $5,500 per year for pathologists to almost $30,000 per year for orthopedic surgeons and other, high risk surgery specialties. (Correspondence from the California Association of Professional Liability Insurers to Speaker Antonio Villaraigosa, April 7, 1999, p. 2, on file with the Committee. Hereafter "Professional Liability Insurers Correspondence.")

In support of the proposition that the MICRA cap has saved millions of dollars in physician and consumer costs, insurers also cite a controversial 1998 report conducted for Californians Allied for Patient Protection (CAPP), which represents a number of health care industry organizations, by LECG, Inc. of Emeryville. This report, popularly known as the Hamm Report (after William Hamm, Ph.D., a former Legislative Analyst to the California Legislature who helped draft the report), concluded, among other

things, that MICRA saved carriers $516 million in claims payments from 1986-96, and that "most of the savings should be attributed to the cap on non-economic damages." (Hamm Report at p. 10.)

According to the Hamm Report, increased damage awards resulting from any raise in the MICRA cap (presumably even those solely reflecting a cost-of-living adjustment) will influence medical malpractice insurance premiums for several reasons. First, medical malpractice insurance premiums, like all insurance premiums, are primarily determined by the insurer's cost of providing insurance and paying claims. Over time, an increase in these costs will be passed along to policyholders in the form of higher insurance premiums. Second, the cap on non-economic damages affects the cost of medical malpractice insurance in three primary ways: a) by reducing the incentive to litigate weak or marginal claims; b) by reducing the average size of large malpractice claims; and c) by reducing total "loss costs," or costs associated with insurer pay-outs for malpractice judgments.

However, the Consumer Attorneys of California strongly reject the claim that medical malpractice lawsuits are to blame for rising health care costs. They cite a report by the National Association of Insurance Commissioners entitled "Report on Profitability By-Line, By-State 1993-1997" which concluded that medical malpractice is not a substantial contributor to rising health care costs. They also cite a 1999 report prepared by actuary J. Robert Hunter, the Consumer Federation of America Director of Insurance and former Texas Insurance Commissioner, entitled "Medical Malpractice Insurance," which found that medical malpractice insurance costs represented only 0.6% of health care costs in California.

The report also found that, while medical malpractice premiums rose in absolute dollars over the decade, the contribution medical malpractice insurance costs made to overall national health care costs fell. It also determined that nationwide health care costs are driven by hospitals (34%), physicians (19.9%), nursing homes (7.6%), drugs (7.2%), and administration (4.6%). At 0.6%, medical malpractice is the smallest factor. Finally, the Consumer Federation of America report compared 1993 state-by-state health care costs with the states that have instituted a damage cap and determined that there does not appear to be a pattern that suggests that non-economic damages caps result in measurable lower costs relative to health care costs overall.

In 1992, the non-partisan Congressional Budget Office (CBO) also released a study entitled "Economic Implications of Rising Health Care Costs," which posed the question "What has caused the rapid increase in health expenditures?" In answering this question, the study looked at several issues including the development and use of new medical technologies, the growing use of third-party payers, and the malpractice issue. The study concluded that, with respect to malpractice, higher medical malpractice costs account for little of the increase in the nation's health care costs. In reaching this conclusion, the CBO noted that malpractice premiums amount to less than one percent of national health expenditures and therefore "directly contribute little to the nation's overall health costs." Additionally, in a statement before the House Ways and Means Committee on March 4, 1992, the director of the CBO, stated that restructuring malpractice liability alone would not generate large savings in the nation's health care costs.

Issue #4: Do Most Medical Malpractice Victims Receive Inappropriately Large Awards? Some critics of changing MICRA's damages cap in any manner (presumably including an adjustment based on changes in the cost of living) have asserted that typical medical malpractice victims receive windfalls by juries.

And the Professional Liability Insurers claim that medical malpractice awards will rise due to any future increase in the cap on non-economic damages, whether or not the underlying facts of the case justify additional awards. (Professional Liability Insurers Correspondence at p.4.)

According to the Consumer Federation of America report, however, over the past decade only one in four (26.6%) medical malpractice claimants nationwide received any compensation at all for their claims. Stated another way, fully three quarters (73.4%) of med-mal claimants received no payment at all for their alleged injuries. The report also found that, on a nationwide basis, in cases where a claimant received a payment, the average amount received was less than $100,000. For all medical malpractice claimants, including those who received a payment and those who did not, the average amount received was $25,923.

Issue #5: Will Indexing the Cap Reduce Access to Quality Health Care? The Hamm Report asserts that higher malpractice premiums brought about by any higher cap on non-economic damages (presumably even one simply reflecting a higher cost of living), will "consume a larger share of self-insured hospitals' budgets, decreasing the hospitals' ability to provide uncompensated care." (Hamm Report at p. 24.) The study asserts that most hospitals self-insure, rather than purchase malpractice insurance from an insurance company, and that these hospitals establish self-insurance trusts that they administer themselves or contract with third parties to administer. Current hospital reserves are based on the $250,000 cap on non-economic damages. If the cap is increased, the report concludes, hospitals that set aside reserves for medical malpractice will be forced to increase their budgets for medical malpractice expenditures and reserves – and will reduce patient services. (Id.)

The California Nurses Association disagrees with this assumption, and asserts that the current method of determining damages for medical malpractice injury itself results in age, gender and socio-economic disparities, stating:

> Current methods negatively and disproportionately affect infants, children, most women and low wage earners since compensation is based on the projection of the injured person's income earning potential.…The CNA is compelled to point out that the same people who are most at risk for access to health care are currently disadvantaged by the two-tiered legal system in compensation for medical injury. Infants, children, most women, retirees and low wage earners are compensated far less due to the current practice of calculating economic damages resulting from medical malpractice injury. Economic damages are based on factors like work history and demonstrable income earning potential. Failing to increase compensation for those affected categories of patients by continuing to cap the non-economic damage portion should not be viewed as a "trade" for a promise of maintaining a status quo or affording more access to health care. It is a suspect argument that keeping a lid on a twenty-year old MICRA cap would necessarily make coverage more readily available or drive up health care costs disproportionately. Rather, factors like income level, race, part-time work status, and the refusal of many employers to offer health insurance are widely documented to be linked to health insurance status.

Issue #6: Will Adjusting the Cap Through the Use of a Cost-of-Living Index Increase "Defensive Medicine" Costs in California? The Hamm Report asserts that any raise in the MICRA cap (even presumably one reflecting a higher cost-of-living), will invariably increase the amount of unnecessary medical treatment, and thus the cost of health care in California. The study states that health care providers can reduce their exposure to malpractice costs by altering their behavior in ways that increase the cost of health care without improving the quality or effectiveness of health care through "defensive medicine." According to the report, tort reforms like the MICRA cap may save California consumers and taxpayers "approximately $5.8 billion" through the avoidance of so-called "defensive medicine," and "the direct and indirect costs resulting from a higher cap on non-economic damages could [conversely] exceed $6 billion." (Hamm Report at p.16.)

According to Consumers for Quality Care, however, a 1994 Congressional Office of Technological Assessment report found that less than eight percent of all diagnostic tests are performed primarily because of doctors' fears of medical malpractice lawsuits. In addition, the Consumer Federation of America report states that the cost of defensive medicine has dropped most likely because more people are enrolled in HMOs which use capitation rather than traditional fee-for-service medicine. J. Robert Hunter, the author of the Consumer Federation of America report, argues that capitation creates a financial incentive not to order unnecessary tests because the fewer services the provider orders, the more the provider earns.

Issue #7: Will Proposition 103 Enable the Insurance Commissioner to Keep Malpractice Insurance Rate Increases Down? One of the major areas of contention in the MICRA debate is the likely effect Proposition 103 would have in mitigating any increases in medical malpractice insurance rates that opponents claim will occur should the cap be raised pursuant to a cost-of-living increase. When MICRA was enacted, California did not effectively regulate malpractice insurance rates. "Carriers could jack up their prices with virtual impunity. They could implement rate hikes without justifying them or obtaining prior approval from the insurance commissioner. The commissioner could find rates excessive and order rollbacks, but only after the fact and only if the marketplace lacked competition." (Dresslar at p. 1.)

In 1998, however, California voters enacted Proposition 103, which, among other things, permits physicians to challenge insurers' rate requests in public hearings before the commissioner, and to pay only rates that are determined to be legally justified. (Insurance Code section 1861.05.) Proponents of indexing the MICRA cap therefore note that any assertions that medical malpractice rates will rise if the cap is raised to reflect increases in the cost-of-living may be improperly assuming that the state's insurance commissioner will automatically find such increases legally justified.

Indeed, under Proposition 103, rates (other than those of the Cooperative of American Physicians/Mutual Protection Trust, which is regulated by the Department of Corporations and not the commissioner), must be approved by the commissioner before they can be used. Insurers must justify any increases based on projected claims costs, overhead and profit margin. In addition, if insurers want to raise rates more than 15 percent the commissioner has to hold a public hearing, if requested by any individual. During the proceedings, intervenors can challenge increases by presenting their own evidence and rebutting the insurers. (Insurance Code sections 18614.05, 1861.08, and 1861.10.)

> Finally, any person can go to court to overturn the commissioner's rate decisions. Thus physicians and other interested parties have a forum to challenge efforts by carriers to use a change in the MICRA cap as an excuse to unreasonably raise malpractice insurance prices. Insurers will, in part, have to show how much of their previous claims losses were attributable to the $250,000 limit, and how much more they expect to pay because of the higher number. (Dresslar, at p. 9.)

Opponents of raising the cap (presumably even through the addition of a cost-of-living index) note, however, that most hospitals self-insure, rather than purchase malpractice insurance from an insurance company. These hospitals pay into a self-insurance trust, which provides a source of payments for claims as they accrue. The contributions are based on an actuarial determination of future payments, which is based on historical and expected losses. (See, Hamm Report at p.24.) Thus they argue that anticipated rate hikes will invariably reduce access to quality health care by those who need it most and can afford it least.

Issue #8: Have Malpractice Carriers Unfairly Profited From Their Malpractice Lines? According to the Consumer Attorneys of California, a 1997 report by the National Association of Insurance Commissioners entitled "Report on Profitability By-Line By-State" determined that medical malpractice is the most profitable insurance line in California, and medical malpractice insurance profits are ten times greater than the profits of other lines of insurance. This same report found that, over the past decade, the average profit for California medical malpractice insurers was 25.4% of the collected premium. According to the report, the average profit for all lines was 2.6%, 6.8% for private automobile insurance, - 4.2% for multiple peril homeowners' insurance, and 10.6% for fire insurance.

The Consumer Attorneys of California also note that State Department of Insurance statistics indicate that, in 1997, California medical malpractice insurers earned over $763 million while paying out less than $300 million to claimants. And the Consumer Federation of America asserts that medical malpractice insurance profits over the last ten years were a whopping 65% higher than the rest of the property/casualty insurance business.

Insurers argue that they have not unfairly profited from their medical malpractice insurance lines in California. In support of this claim, they cite statements made in the Hamm Report asserting that economic realities ensure that it is not possible for California malpractice insurers to make unreasonable profits on their insurance lines in the long run:

> Economic theory holds that prices must be high enough to enable firms to cover their costs and earn a competitive rate of return. If market conditions temporarily allow firms to earn returns exceeding the competitive rate, new firms will enter the market and drive down prices, thereby eliminating any excess profits. Similarly, if competition pushes prices below the point where firms cannot earn a reasonable return, some firms will leave the market, causing prices to rise. Thus, the competitive process tends to force prices to the level where firms are able to cover their costs and earn a competitive return, but not an excessive return… There is no reason to believe that the market for medical malpractice insurance is exempt from the competitive forces that keep prices in check elsewhere in the economy. To the contrary, the available evidence indicates that

competition keeps prices for medical malpractice insurance in check. (Hamm Report at p. 11.)

Issue #9: Would Adjusting the Cap Through the Use of a Cost-of-Living Index Affect the Supply of Doctors in California? According to the Professional Liability Insurers, raising the MICRA cap in any way (presumably even to reflect a higher cost of living), will reduce the supply of doctors in California. They state that University of California medical schools have recently reported a dramatic, unexplained, increase in the amount of medical malpractice premiums they are paying each year. As a result, they assert, the amount of funds available to train new California doctors is "dwindling." (Professional Liability Insurers Correspondence at p.3.)

The Hamm Report also concludes that raising the cap in any way will reduce the supply of available doctors in certain "high risk" specialty areas in California. The study suggests that higher malpractice premiums translate into lower incomes for physicians, especially for those specializing in obstetrics and other "high risk" specialties. "These high premiums and correspondingly lower incomes discourage medical students from entering into obstetrics or high risk specialties. In addition, physicians approaching retirement will have a greater incentive to retire earlier instead of later." (Hamm Report at p. 22.)

The report also cites a recent nationwide survey by the American College of Obstetricians and Gynecologists, in which 8.9% of obstetricians said they decided not to practice their specialty due to malpractice premiums, and 8.6% of obstetricians said they decreased gynecological surgical procedures as a result of malpractice risk. (The American College of Obstetricians and Gynecologists, Overview of the 1996 Professional Liability Survey, 1996, p.4.) The same survey found that in California specifically, 7.3% of obstetricians no longer practiced obstetrics due to the risk of malpractice, and 7.4% of obstetricians have decreased gynecological surgical procedures as a result of the risk of malpractice. (Id. at 2.)

According to the Consumer Attorneys of California, however, a 1997 Morgan Quitno Press study, entitled "Health Care State Rankings," found no relation between caps on non-economic damages and access to health care. In determining that caps on non-economic damages are insignificant in terms of health care costs, the study compared states with damage caps and states without damage caps and found that in states with caps there were 31.5 general/family practice doctors per 100,000 population, and in states without caps there were 28.80 such doctors. Another study by the Morgan Quitno Press in 1998, entitled "Health Care State Rankings," similarly found no correlation between non-economic damage caps and the number of OB/GYNs. The study found that in 1996, there were 27.8 OB/GYNs per 100,000 women in states without damage caps and 25.3 OB/GYNs per 100,000 women in states with damage caps.

Issue #10: Is the Industry Commissioned Hamm Report Fair and Accurate? Given the substantial reliance placed upon the Hamm Report by the health care industry that paid for it, it appears appropriate to note that both the integrity and reliability of the report itself has become one of the major "flash points" in the MICRA cap debate. According to Consumers for Quality Care, a Southern California-based consumer rights organization, the Hamm Report is "a biased and selective text that assumes its own conclusion. It is designed not to enlighten, but only to advocate for the continuation of the $250,000 cap

on the pain and suffering of victims of medical malpractice." ("Consumer Response to Industry Report on MICRA," May 5, 1999, p. 1. On file with the Committee, hereafter "Hamm Report Consumer Critique.")

Among other things, this consumer organization makes the following substantial criticisms about the report:

1. "The study's projection of increases in health care costs fails to take into account the fact that tort systems deter unnecessary injuries and their costs. Dr. Troyen Brennan of the Harvard School of Public Health, co-author of the landmark Harvard Medical Malpractice Study, found that the health care system wastes $60 billion annually to care for injuries attributable to undeterred medical negligence. The landmark Harvard Medical Malpractice Study found that medical malpractice causes 300,000 injuries annually in hospitals alone. As Brennan points out, the deterrent effect of strong tort laws curtails such staggering costs." (Hamm Report Consumer Critique at p. 1.)

2. "The report wrongly attributes health care cost increases to the costs of 'defensive medicine,' procedures purportedly ordered due to fear of lawsuits. Government studies show such costs are minimal and that managed care, in fact, has created opposite incentives." (Id.)

3. "The report outrageously claims that "caps on damages awards are an especially effective deterrent to claims of 'dubious merit'." In fact, low income individuals, home-makers, students and children with meritorious claims are singled out by such a non-economic compensation cap. These groups do not have significant wage loss, therefore, under the … [Hamm Report's] theory, their claims are 'dubious'." (Id. at p. 2.)

4. "The premium comparisons cited in the report are meaningless because two of the four selected states also have statutory caps on damages. The premium comparison is apparently supposed to show that malpractice insurance premiums are higher in states without a cap, the comparison is useless." (Id. at p. 3.)

5. "The report inappropriately compares the effect of an increase in California's MICRA cap with other states. The report contends that malpractice insurance premium costs will increase if the cap is increased. That projection is based on a study in New York that supposedly calculated the costs of introducing a new cap in that state…[I]t is wrong to assume that the cost impact of the introduction of a new cap would be equivalent to the effect of an increase in the 23 year old cap already in statute in California." (Id.)

6. "There is no evidence to justify any of the dire predictions made in this report. The report claims that doctors will flee the state, malpractice insurance premiums will skyrocket, health clinics will close, and specialists will not be available. More than one-half of the states have no cap on damages, where is the evidence that these calamities have occurred in these states?" (Id.)

Issue #11: Will Adjusting the Cap Through the Use of a Cost-of-Living Index Increase the Number of Med-Mal Lawsuits Filed? According to the Hamm Report, raising the MICRA cap in the future (presumably even to reflect a higher cost-of-living) will substantially increase the number of medical malpractice lawsuits filed in California for several reasons. According to the study, increasing the

potential rewards from pursuing malpractice claims will increase the incentive of individuals with dubious claims to file lawsuits. It will also reduce their incentive to accept out-of court settlements. "Caps on damages awards are an especially effective deterrent to claims of dubious merit because they create a greater incentive for attorneys to settle before going to trial. This is because the cap effectively limits the maximum fee that the attorney can expect to receive from going to trial. By effectively limiting attorney's fees, the cap will also affect settlement negotiations, and discourage the plaintiff from holding out for a better settlement." (Hamm Report at p. 5.)

The Professional Liability Insurers also assert that raising the MICRA cap in any way will increase the number of medical malpractice liability suits in California. They claim that during the years immediately preceding the enactment of MICRA, the frequency of medical malpractice liability suits increased by about 12% per year. Since enactment of MICRA, they claim, the number of medical malpractice suits per capita has remained at a relatively constant level demonstrating that MICRA controls, but does not unreasonably suppress, the number of suits filed. They conclude: "Should the MICRA cap be raised, we can anticipate a sharp increase in the number of medical malpractice suits brought against California physicians. Determining the precise level of increase is probably beyond the powers of mathematical science and resides in the realm of behavioral science. In addition to increasing the frequency, we can be readily certain that the severity of suits will also increase. MICRA has not done as good a job controlling the severity of awards as it has done controlling the frequency of medical malpractice suits." (Professional Liability Insurers Correspondence at p.3.)

Consumer Attorneys of California reject the assertion that raising the cap will lead to an explosion of medical malpractice claims against doctors, however. They cite a 1990 report by the Harvard Medical Practice Study entitled "Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York," which found that only one out of eight victims of medical malpractice filed a malpractice claim. This study focused on the experience in New York, a state without a damages cap. Arguably, a state with a damages cap would find even fewer victims of medical malpractice undergoing the time and expense of filing a malpractice claim because the available compensation would be less.

They also argue that there is little incentive to bring a frivolous medical malpractice suit because the cost of bringing the suit is expensive. According to Ken Sigelman, the Medical Malpractice Chair for the Consumer Attorneys, the cost of a medical malpractice lawsuit often ranges from $50,000 to $100,000, which includes $1,500-$3,000 for investigating a potential case, $2,500-$5,000 to call an expert witness at trial, and $200-$1,000 for each deposition.

ARGUMENTS IN SUPPORT AND OPPOSITION: Given the intensity of the MICRA reform debate over the past several years in California, it is not surprising that the Committee has received a large volume of correspondence for and against adjusting MICRA, with the greatest volume of mail sent by physicians who strongly oppose any reform of MICRA. Following is a sample of the principal arguments made in favor of and in opposition to the bill when many believed the damages cap itself would be raised. However, it is assumed that the positions noted will not change with the latest amendments to the legislation. The complete list of supporters and opponents of the measure follows thereafter.

Supporters' Arguments: The California Nurses Association (CNA) writes in support of the bill, stating that the MICRA cap on non-economic damages should be raised to a level that reflects what it would be

worth if a COLA had been properly incorporated in the 1975 statute. Furthermore, CNA argues, any change in the MICRA non-economic damage cap should be accompanied by a COLA for future adjustment. CNA further argues that medical malpractice is not to blame for rising health care costs, but rather points to many factors that are causally linked to cost increases, including one causal factor of particular note – a four year "pattern of premium freezes or low increases [by HMOs, during which time] HMOs pursued a strategy of increasing their market share through predatory price competition."

Consumers for Quality Care writes in strong support of the bill that "recent studies show that medical malpractice is a growing national epidemic claiming the lives of 80,000 Americans annually in hospitals alone: more than the death toll from highway crashes and AIDS combined [citing Harvard School of Public Health projections based on Harvard Medical Practice Study Group, Harvard University, 1990] ... If adjusted for inflation, the MICRA cap would allow victims $897,000 today... Wrong-doers have been spared punishment and medical malpractice victims have been ruthlessly denied adequate compensation for their injuries by this twenty three year old failed experiment in tort law. Crippled children, who must suffer an entire lifetime for a negligent doctor's actions, have paid a particularly high price for MICRA's one-size-fits-all cap ... AB 1380 is much-needed legislation to raise MICRA's arbitrary cap and help patients find legal representation and receive just compensation."

Consumer Action, a statewide non-profit consumer organization, states in support of the bill that "access to health care is intimately connected with the quality of that care. AB 1380 would increase the quality of care by holding the very small number of bad medical professionals responsible for their wrongful conduct ... Raising the MICRA cap will not have a substantial impact on competent medical providers. Statistics have consistently demonstrated that caps on non-economic damages do not affect medical or medical malpractice insurance rates. Medical malpractice insurers simply pocket extra profits. Those impacted by your legislation will be the tiny percentage of doctors who cause terrible injuries to their patients. They will, in turn, be forced to internalize the true costs of their misconduct."

Neighbor to Neighbor, another consumer protection group, writes that working families need the protection of the civil justice system in order to get quality health care. By treating economic and non-economic damages differently, the group suggests, MICRA creates a two-tiered legal system which hurts low wage earners who are more likely to suffer significant harm other than lost salary. They state that only one other state in the country has restrictions more stringent than California's MICRA, yet California's health care costs are among the highest in the nation, concluding that "at a minimum, MICRA needs a cost-of-living adjustment. More and more California patients are killed or injured by questionable doctors every year. And if the victims don't suffer economic damages, they'll have extraordinary difficulty finding an attorney who can take the financial risk to argue their case. MICRA should either be raised to a level where patients can get attorneys, or it should be eliminated altogether."

The Center for Public Interest Law strongly supports the bill, stating that:

> Simply making affordable health insurance available to the uninsured does not equal quality health care. And no California policymaker should be swayed by the argument that we must settle for substandard care or further restrict legal remedies in our quest to expand the ranks of the insured... CPIL religiously monitors all Medical Board meetings. It has become abundantly clear that the promise of a strong and independent Medical

> Board - the bargain struck in exchange for a cap on non-economic damages 24 years ago when MICRA was enacted - has not materialized.

The Center for Public Interest Law also believes that the MICRA cap, particularly in the current managed care environment, is counterproductive to the health care needs of Californians, particularly children. It warns that "A person whose life is changed forever because of a provider's misconduct deserves fair compensation – and the current cap has been ravaged by inflation over the past 24 years, rendering it wholly inadequate."

Opponents' Arguments: The California Medical Association (CMA), many physicians and health care organizations, and many others wrote the Committee in strong opposition to the bill. In a nutshell, they claim that MICRA is working just as it was intended to, and it would be a huge mistake to revise it in any way, presumably including the addition of a cost-of-living factor.

Following is the statement CMA provided the Committee in opposition to the bill:

> … MICRA keeps malpractice insurance premiums affordable and allows physicians to continue to provide care to all Californians, despite managed care. Without MICRA, people who receive medical care -- including the estimated 7 million uninsured, the indigent and the undocumented – in inner-city, rural, and ethnic clinics, long-term and hospice care facilities, and all other self insured health centers, as well as, county, state, and University of California hospitals would be placed at risk if their physicians could no longer practice in such a facility, or the facility had to close…
>
> Prior to the MICRA reforms, the cost of malpractice insurance in California was exceeded only by New York. Today, malpractice premiums are markedly lower when compared to non-MICRA states. As a result, more dollars are available for health care services for the indigent and uninsured and access to high-risk specialties…
>
> On the other side of the scale, MICRA has neither reduced malpractice litigation nor limited access to the courts. According to the 24th Annual Survey conducted by the Medical Underwriters of California, since the enactment of MICRA in 1975, major malpractice cases have increased from 32 in 1976 to 147 in 1996; and, the average major malpractice award has increased from $410,855 in 1976 to $840,219 in 1996….
>
> A brief review of our own malpractice crisis here in California and a current comparison between California and other states across the country shows that if the MICRA cap is lifted, malpractice premium costs for all physicians would more than double… As a result, and in addition to an across-the-board increase in health care costs, the downside adverse impact on the "safety net" hospitals (i.e., U.C. teaching hospitals, public hospitals, children's hospitals) would be disastrous…

Californians Allied for Patient Protection (CAPP), comprised of a host of health care organizations, also opposes the bill, writing:

> Society benefits more from leaving the cap unchanged rather than, as AB 1380 asserts, increasing the quarter million dollar cap…. MICRA imposes no cap on awards for economic damages. Malpractice carriers report that between 1984 and 1997, payments to plaintiffs and their lawyers increased 139 percent in California. In contrast, the cost of living increased during that time only 54.5 percent. A plaintiff who received $500,000 in 1984, where one half was for non-economic damages, would receive $1,195,000 today, or $422,500 more than what the injury is worth measured by the cost-of-living increase. Thus, the average medical malpractice award or settlement, adjusted for 1975 dollars, is more now than when MICRA was enacted… [and] MICRA's ceiling on non-economic damages has been pierced or evaded by judicial interpretation and is constantly under threat of erosion.
>
> Findings in AB 1380 also state that the cap disadvantages women, children, the elderly, and lower income Californians. The truth of the matter is that these are the very people the MICRA limitation helps the most… The $250,000 cap protects access to health care services for people with lower incomes. They would rather see a doctor than sue a doctor…

Planned Parenthood Affiliates of California writes in opposition to the bill, citing the concern that increasing the MICRA cap (presumably even to reflect increases in the cost-of-living) will have the unintended effect of reducing access to women's health services. In opposition to increasing the MICRA cap, Planned Parenthood states:

> As a safety-net provider, we have no ability to transfer our increased costs to our patients, our landlords will not lower our rent and our staff salaries are well below market rates. Further, we are already fundraising to help subsidize care we are currently providing – we have no alternative to offset any increased costs except a reduction in services.

Planned Parenthood provided the Committee a copy of a report entitled "MICRA: Protecting California Women's Access to Health Care," which asserts that, if the current cap is raised, serious public health consequences for women are inevitable. The report states several inadvertent consequences of raising the MICRA cap, including that (1) the number of obstetric providers will decrease, worsening an already critical situation, (2) women in under-served areas will be particularly hard hit by any reduction in providers, (3) non-profit community clinics will have no alternative but to cut back their services as a result of higher insurance costs, (4) women's access to early prenatal care will be adversely affected if the number of obstetric providers is reduced, (5) women's access to general health care will also be negatively impacted if California loses more providers, and (6) a greater number of women will move into the ranks of the uninsured because an increase in the MICRA cap will significantly increase health care costs, thus discouraging employers from offering benefits.

In highlighting the need for the MICRA cap, the report states:

> By helping control professional liability costs, MICRA has played a special role in stabilizing the health care delivery system for women. The most dramatic impact is in

> obstetrics, the practice most vulnerable to litigation, where it has slowed a persistent trend among physicians to stop delivering babies. MICRA has also enabled the critical "safety net" of community clinics to maintain services for California's rapidly growing uninsured and underinsured population.

The California Hispanic Health Care Association (CHHCA) also writes in opposition to the bill. A policy paper prepared by CHHCA on the issue of raising the MICRA cap, entitled "The Impact of Raising the Medical Injury Comprehensive Reform Act (MICRA) Cap on Community-Based Medical Providers Serving the Uninsured: A Case Study," focuses on the consequences an increased MICRA cap would have on the Community Health Foundation of East Los Angeles (CHFELA), which provides medical services to working poor and uninsured patients. The policy paper notes:

> If the MICRA cap were to increase to … $900,000 or higher, CHFELA has estimated its premium payments could increase $150,000 to $250,000 annually. This would result in 16,000 to 28,000 fewer patient visits being provided to 4,200 to 7,800 fewer patients. The consequences of this action cannot be measured alone by these reductions in medical encounters and uninsured patients. It is imperative to bear in mind the degree of medical underservice which currently exists in the CHFELA catchment areas/communities. With the exception of the state of California, Los Angeles County has the highest rate of uninsured persons in the nation. The number of uninsured persons w[ith] MICRA rates increasing would further reduce the number of medical providers in these communities willing to serve the uninsured patient. This would greatly exacerbate the problem of access to primary health care services in East Los Angeles and Southeast Los Angeles Counties….There are no major health initiatives before any political bodies which could mitigate this situation, therefore, problems of access would be even more severe than currently. (Emphasis in original.)

A second policy paper prepared by CHHCA, entitled "The Impact of Increasing the Medical Injury Comprehensive Reform Act (MICRA) Pain and Suffering Cap on California's Central Valley," expresses concern that the traditionally high unemployment rate in the Central Valley, combined with the number of Californians who do not have health insurance means that "it is critical to remove barriers to health care and not to add new obstacles. The MICRA cap has been a safety net for physicians and the uninsured alike. … The cap has stabilized insurance rates due to physicians' limited exposure to financial risk."

This policy paper cites the Hamm Report for the proposition that, if the cap were raised, the result could be as much as a $6 billion increase in California's annual health care costs. The report states "The increased costs would be handed down to those who can afford it the least – individual consumers, families, and taxpayers."

Staff Counsel Comment: In grappling with this challenging public policy issue, the Committee may wish to weigh which side of this debate has presented the most persuasive evidence on the past successes and failures of MICRA's tort reform experiment, and the likely results of adjusting the MICRA cap to keep up with changes in the cost of living. While medical malpractice insurance premiums do appear to have stabilized after MICRA was enacted, it is not clear that this bill's proposed addition of an annual cost-of-living adjustment will necessarily lead to any increases in medical malpractice premiums. Indeed,

proponents of the bill suggest that this will not be the case, and question whether stabilization of insurance premiums was solely or even largely due to the passage of MICRA. They also note that insurance premium stabilization was not the only goal of this landmark statute. The Legislature also sought to preserve the rights of medical malpractice victims to receive sufficient compensation for their injuries.

In testimony prepared for the Judiciary Committee of the United States Senate, one MICRA expert cautioned the Senators that from a public policy perspective, the goal of tort reform is not simply to reduce the costs of claims and of malpractice insurance. Rather, tort reforms like MICRA should be evaluated in the broader context of the fundamental purposes of the tort system, which are deterrence of negligence and reasonable compensation for victims – along with ensuring access to quality health care (in the case of MICRA).

Unfortunately, studies that have tried to measure the deterrent effect of MICRA have been largely inconclusive. It is also difficult to predict with any precision to what extent malpractice insurance premiums might rise, if at all, under annual adjustments to the MICRA cap based on cost-of-living changes – especially in a Proposition 103 environment where the state's insurance commissioner has the power to prohibit unjustified rate increases. However, opponents of changing MICRA also contend that the focus here should not just be on potential increases in premiums and health care costs, but also must be on possible reductions in access to quality health care, especially for low-income patients, and women who need obstetrical or gynecological health services.

Thus, the public policy challenge presented to the Committee is to decide whether the current MICRA cap has generally achieved its objectives of stabilizing insurance premiums and maintaining access to quality health care, or whether its application, particularly in its "un-indexed" form for almost a quarter century, has severely under-compensated those who have been harmed, to the detriment of the victims of medical malpractice.

Prior Related Legislation:

AB 250 (Kuehl) of 1997: Sought to raise the MICRA cap on non-economic damages to $700,000, and to create five exceptions to the cap in cases involving egregious conduct by the health care provider, death, or "catastrophic physical injury" to a child under the age of 14 years. Held on the Assembly Floor.

REGISTERED SUPPORT / OPPOSITION
(As of May 21, 1999):

Support

California Nurses Association
Congress of California Seniors
Consumers for Quality Care
Consumer Federation of California
Consumer Attorneys of California

The Greenlining Institute
Consumer Action
Safe Medicine for Consumers
Neighbor to Neighbor
Center for Public Interest Law
DES Action
California Advocates for Nursing Home Reform
California Applicants' Attorneys Assoc.
CALPIRG
Various Individuals

Opposition

Californians Allied for Patient Protection
California Medical Assoc.
Union of American Physicians & Dentists
Planned Parenthood of California
California Hispanic Health Care Association
American College of Obstetricians & Gynecologists
Farmers Insurance Group
Orange County Citizens Against Lawsuit Abuse
California Assoc. of Obstetricians & Gynecologists
American College of Emergency Physicians
American College of Cardiology
California Society of Plastic Surgeons
Newport Eye Center
California Assoc. of Neurological Surgeons
California Psychiatric Assoc.
California Physicians Group Council
Kaiser Permanente
California Access to Specialty Care Coalition
California Orthopaedic Assoc.
Lompoc Hospital District
California Academy of Family Physicians
Calif. Assoc. of Homes and Services for the Aging
Calif. Society of Anesthesiologists
Calif. Family Health Council
Civil Justice Assoc. of California (formerly ACTR)
Osteopathic Physicians and Surgeons of Calif.
Calif. Assoc. of Professional Liability Insurers
Various Individuals

Analysis Prepared by: Drew Liebert / JUD. / (916) 319-2334